

unpaid civil money penalty or assessment that caused the Surety to pay HCFA under the bond, HCFA will refund to the Surety the amount the Surety paid to HCFA to the extent such amount relates to the matter that was successfully appealed by the HHA (or by the Surety), provided all review, including judicial review, has been completed on such matter. Any additional amounts owing as a result of the appeal will be paid to the HHA.

§ 489.73 Effect of conditions of payment.

If a Surety has paid an amount to HCFA on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and HCFA subsequently collects from the HHA, in whole or in part, on such unpaid claim, civil money penalty, or assessment that was the basis for the Surety's liability, HCFA reimburses the Surety such amount as HCFA collected from the HHA, up to the amount paid by the Surety to HCFA, provided the Surety has no other liability to HCFA under the bond.

(Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh)).

[63 FR 29656, June 1, 1998]

§ 489.74 Incorporation into existing provider agreements.

The requirements of this subpart F are deemed to be incorporated into existing HHA provider agreements effective January 1, 1998.

[63 FR 315, Jan. 5, 1998. Redesignated at 63 FR 29656, June 1, 1998]

Subparts G– H [Reserved]

Subpart I—Advance Directives

SOURCE: 57 FR 8203, Mar. 6, 1992, unless otherwise noted.

§ 489.100 Definition.

For purposes of this part, *advance directive* means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of

health care when the individual is incapacitated.

§ 489.102 Requirements for providers.

(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the provider and are required to:

(1) Provide written information to such individuals concerning—

(i) An individual's rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

(ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:

(A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(B) Identify the state legal authority permitting such objection; and

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(2) Document in the individual's medical record whether or not the individual has executed an advance directive;

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not